(X6) DATE

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101244	or contraction	IDENTIFICATION NOTIFICAL	A. BUILDING:		COMIT LETES	
		125046	B. WING		01/22/2020	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
PU'UWAI '	O MAKAHA	84-390 JAI WAIANAE,	DE STREET HI 96792			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	Ē
4 000	Initial Comments		4 000			
	facility from 01/14/202	urvey was conducted at the 20 - 01/22/2020. The 69 residents at the time of				
4 159	11-94.1-41(a) Storage	e and handling of food	4 159		2/22/20	
	distributed, and serve	procured, stored, prepared, ed under sanitary conditions.				
	(1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and					
	(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.					
	failed to ensure all for and served under sar of three dining observed two dining areas and numerous flies in the were having their medicient practice had transmission of disea affect all residents residents include: On 01/14/20 at 12:00 observation in the Sta	n and interviews, the facility od was prepared, distributed nitary conditions during two vations of the kitchen, the resident rooms. There were building while the residents als or in their rooms. This the potential to cause the se and/or infection and		Residents 6, 22, 35, 38 and 40 did experience disease transmission nor infection related to the pests. Exposed Residents were monitore ensure they did not experience diseas transmission or infections related to tralleged practice. Facility'□s pest control company conducted a two-day targeted treatme for the flies beginning on 1/15/2020. T pest control company provided the face a spot spray that will assist in controlli sudden fly occurrences and for use as early response on those occasions. A review of the physical structure and routines was conducted and modificate.	d to see e ent the cility ng s an	
		aides (CNAs) was trying to		to the process were implemented to		

Office of Health Care Assurance

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 02/05/20

TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
		125046	B. WING		01/22/2020		
NAME OF PROVIDER OR SUPPLIER PU'UWAI 'O MAKAHA 84-390 JAE			DDRESS, CITY, ST. ADE STREET IE, HI 96792	DDRESS, CITY, STATE, ZIP CODE ADE STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE		
4 159	seen flying around the other staff were seen they landed on the conservice area and on the residents were sitting. On 01/14/20 at 12:10 her meal delivered to on her overbed table, instead of the pork accentree that day. R38 her bedside which shable to the right of he 11:13 AM, during an insometimes flies come that is sortated from Yeah, the spaghetti. If that day, and acknow when surveyor observated bedside. R38 said R38 said her the red sweapon. On 01/14/20 at 12:16 Station 2 dining room who was sitting in a man swatthe flies around resident ate. The famblue fly swatter and won the table several time. On 01/14/20 at 12:20 in-room lunch tray to bedside and the fly fleside. On 01/14/20 at 12:31	then many more flies were edining room. CNA1 and trying wave the flies off as cuntertops of the kitchen he dining tables where the he room and it was placed R38 requested a sandwich dobo which was the lunch also had a red fly swatter at the moved to another overbed or bed area. On 01/17/20 at anterview with R38, she said, the in because of the food, the egary taste, pork adobotom tuna and spaghetti. She said, "I swatted one wiedged it was on 01/14/19 wed she had a red fly swatter, "the flies drives me crazy!" fly swatter was, "my PM, observation of the saw R22's family member, notorized scooter, trying to the he hilly member was using a was seen smacking it down	4 159	reduce access points. Facility staff were in-serviced regardi infection control related to pest control early response and dining procedure 4. Audits of resident living areas will conducted by Administrator and/or designee to monitor for flies. Audits be conducted weekly until substantia compliance is achieved per review by committee. Results of the audits will reported to the QA Committee for revand recommendations if necessary. Responsible Party: Administrator and designee	ol, s. be will I v QA be iew		

Office of Health Care Assurance

STATE FORM 6899 77HP11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED				
		125046	B. WING		01/22/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
PU'UWAI	PU'UWAI 'O MAKAHA 84-390 JADE STREET WAIANAE, HI 96792						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE		
4 159	Continued From page season," all the flies vor On 01/15/20 at 12:09 R40's hand while he is R40 waved that fly aw flies flying around him R40 was also trying to hand while trying to e staff server (KSS) sai "sometimes they oper kitchen)." Then, at the supervisor (KS) walkedoor, and the KSS sa out loud that while he out (a fly). On 01/15/20 at 12:12 "Yeah, the flies, long the flies," and one fly ther which a CNA removed On 01/15/20 at 12:15 the flies, not good for hates flies." On 01/15/20 at 12:23 flying around in the State Several of the flies we cup, with two more flie and one fly on the tab sickening, it's sickening registered dietitian (R asked to see the num The RD saw it, apologimmediately removed and the flies flew off in	vere coming out. PM, one fly landed on began to eat his sandwich. Vay along with many other in R6, who was sitting near to shoo away flies with one at his lunch The kitchen in the door in the back (of the at time, the kitchen from that id, "like that." The KS said let one in, he also let one PM, R40 said to surveyor, time." R6 said, "too many in landed on his water cup, in landed on his water cup, in the food. My (relative), she PM, many, many flies were tation 2 dining room. PM, many, many flies were tation 2 dining room. In and around R6's tea in and R6's tea in and R6's tea in and R6's tea in and R6's teader. Tit's	4 159				
	these flies around him On 01/15/20 at 12:36	n.					

Office of Health Care Assurance

STATE FORM 6899 77HP11 If continuation sheet 3 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
		125046	B. WING		01/22/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	
DUUUNAAL	IO MAICALLA	84-390 J	ADE STREET		
PU'UWAI	'O MAKAHA	WAIANAI	E, HI 96792		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
4 159	4 159 Continued From page 3		4 159		
	seen flies in the dining HK1 said, "when I cle then." HK1 said his s for two weeks and thu On 01/15/20 at 12:58 with the Director of Ni Clinical Operations Si they heard about the dining room. They we and were trying the uslower dining room (St amount of flies than Si per observations done the kitchen/dining revistated they considere Station 2 kitchen as a opened by the KS for adjoining kitchen. Th curtain and would open	PM, during an interview ursing (DON) and the pecialist (COS), they stated fly problems in the Station 2 ere also trying to figure it out se of overhead fans in the ation 1, which had a lesser station 2, but yet had flies e by another surveyor during iews there). The COS d the back door in the probable factor since it was			
	On 01/15/20 at 01:07 Infection Preventionis said she heard about facility maintenance of contact with their pessadditional spraying of said they were going. When she was querie of the flies, the IP said rain and everything at area they'd gravitate of cleaning with the flies are closed and fans in (vendor) to do more so When the IP was furth observed lack of resp	PM, an interview with the t (IP) was done. The IP the fly problem and the lirector (FMD) was in t control vendor for the grounds. The IP also to re-assess their lighting. It does not not to the potential source of the grounds in the potential source of the potential source of the notion of the potential source of the p			

Office of Health Care Assurance

STATE FORM 6899 77HP11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		125046	B. WING		01	/22/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE				
DUULWAL	PU'UWAI 'O MAKAHA 84-390 JADE STREET							
PU UWAI	OWAKANA	WAIANA	E, HI 96792					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
4 159	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		4 159					
	aware of this current to was asked to come so FMD said his future putreatments with follow understood the obsert was being served in a							
	with the Administrator "coming today and wi	PM, during a brief meeting s, she stated their vendor, Il work on putting up more was their rainy season and with it now. The						

Office of Health Care Assurance

STATE FORM 6899 77HP11 If continuation sheet 5 of 6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		125046	B. WING		01/22/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PU'UWAI '	O MAKAHA	84-390 JAI WAIANAE	DE STREET			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
4 159	Continued From page	e 5	4 159			
	Administrator acknowledged and stated, "we need to have more of an immediate response to this."					
	fly flying around in the	e for the dinner meal. lining rooms found only one e Station 2 dining room, and rs and/or the resident rooms				
	the kitchen (Station C Cook1 and Kitchen S observed there were around the Main Kitch	:17 AM, during initial tour of One's Main Kitchen) with upervisor (KS) it was numerous large flies flying nen. Kitchen staff present in erved not to be concerned or				
	Two's Satellite Kitche observed major fly int Queried KS if the faci help eradicate the flie ECO Lab and procee ceiling where a half d wall below the ceiling and never come out.	AM, upon entering Station in with KS, immediately festation in the kitchen. Elity uses any devices that its. KS stated yes, they use ded to point towards the ome was mounted on the . KS stated the flies go in KS stated when they clean is are inside the dome.				

Office of Health Care Assurance

STATE FORM 6899 77HP11 If continuation sheet 6 of 6